CONCEPTS OF INDEPENDENCE
CONCEPTS OF INDEPENDENT CHOICES

PERSONAL ASSISTANT
CHANGE OF ADDRESS / PHONE NUMBER

Incomplete forms will not be processed.

PERSONAL ASSISTANT'S SOCIAL SECURITY: _____ PHONE: (_____) _____

LAST NAME: _____ FIRST NAME _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS (*if different from Physical Address*): _____

CITY: _____ STATE: _____ ZIP: _____

THE CONSUMER I WORK FOR IS: _____, WHO RESIDES AT:
(CONSUMER'S ADDRESS): _____

DO YOU RESIDE AT THE SAME ADDRESS AS THE CONSUMER? ( ) Yes ( ) NO

☐ ***CHECK HERE IF YOU ARE NOT CURRENTLY WORKING FOR A CONCEPTS' CONSUMER.*** *Last Day Worked:* _____

I understand that under the New York State Personal Care Services regulation 18 NYCRR § 505.28 (b)(3), a Consumer Directed Personal Assistant may not reside with the consumer whom he or she works for, and failure to disclose this information may be considered Medicaid fraud. By my signature below I attest that the information provided on this form is true and correct, and agree to notify Concepts of Independence / Concepts of Independent Choices (Concepts) immediately of any change.

_____ _____
PERSONAL ASSISTANT'S SIGNATURE **DATE**

If you are currently working for a Concepts' consumer, this section is required:

CONSUMER/ DESIGNATED REPRESENATIVE (D.R.): By my signature below I attest that the Consumer Directed Personal Assistant does not reside at the Consumer's address.

_____ _____
CONSUMER/ D.R. SIGNATURE **DATE**

Concepts is obligated to report all suspected fraud, abuse and false claims to the State of New York Office of the Attorney General Medicaid Fraud Control Unit, the Office of the Medicaid Inspector General, and the City of New York for Medicaid fraud investigation.

OFFICE USE ONLY: DATE RECEIVED: _____ UPSTATE / MCO CTY CODE: _____ P.A. NUMBER: _____

HCPLUS CHANGES: DATE COMPLETED: _____ INITIAL _____

INSURANCE: DATE COMPLETED: _____ INITIAL _____